Colorado Medicaid Hepatitis C Prior Authorization Request Form

Fax completed form and supporting documentation to: 888-772-9696 -for requests sent 10/1/16-2/28/17
Fax completed form and supporting documentation to: 800-424-5881 –for requests sent 3/1/17 and later

Please fill in ALL areas on form to avoid a delay in processing. Determinations for benefit coverage will not be able to be completed until the form is complete including submission of all required lab values/documentation. See the Preferred Drug List (PDL) page 22 -25 for full Hepatitis C PA criteria at: https://www.colorado.gov/hcpf/provider-forms under Pharmacy tab.

Note: The Department will only cover a once per lifetime treatment with any Direct Acting Antiviral

Member name: _____ DOB: _____ Medicaid ID: _____ Gender: male □ female □

1-Has the member previously been treated for chronic Hepatitis C? □ No □ Yes
1a-If yes, please list previous treatment regimen received: _____
- Approximate dates of therapy: _____
- If early discontinuation occurred, please describe: _____

2-Provider attests that member is ready to be compliant to the medication regimen □ No □ Yes
- Prescribers should utilize assessment tools to evaluate readiness of the patient for treatment, some examples are available at: http://www.integration.samhsa.gov/clinicalpractice/screening-tools#drugs or Psychosocial Readiness Evaluation and Preparation for Hepatitis C Treatment (PREP-C) is available at: https://prepc.org/

3-Planned start date of Hepatitis C treatment (week 0): _____ Please note, HCV RNA levels must be submitted at week 4 (Please use today's date if request is for treatment start date of as soon as possible)

4-Provider attests that SVR12 and SVR24 will be submitted timely via fax to 303-866-3590 □ No □ Yes
- Hepatitis C Treatment Outcomes form is accessible at: https://www.colorado.gov/hcpf/provider-forms under Pharmacy tab

5-Member's complete current medication list is attached □ No □ Yes
- Provider attests that significant drug-drug interactions have been screened for and addressed □ No □ Yes

6-Is the member abusing/misusing controlled substances and/or alcohol? □ No □ Yes
6a-If yes, Provider attests that the member been enrolled in counseling or substance use treatment program for at least one month? □ No □ Yes
- Provider referrals can be requested from the member's Behavioral Health Organization by calling customer service, which is accessible at: https://www.colorado.gov/pacific/hcpf/behavioral-health-organizations under "Where is my BHO?"

6b-If yes, please describe: Provider/Facility/Treatment Program AND provide dates that member received services:
Name/Type: _____Dates: _____ _____ _____ _____

7-Is the member female and of childbearing potential? □ No □ Yes
7a-If yes, is pregnancy test attached (must be dated not more than 30 days prior to beginning therapy)? □ No □ Yes
- Is the member planning to become pregnant in the next 12 months? □ No □ Yes

Physician: _____ Phone: _____ Fax: _____ NPI: _____

Prescriber or prescriber agent signature (required): _____ Date: _____

Is the prescriber an infectious disease specialist, gastroenterologist, or hepatologist? □ No □ Yes

If no, is the requested drug being prescribed by a primary care provider in consultation with (**CIRCLE one**) an infectious disease specialist, gastroenterologist, or hepatologist? □ No □ Yes
If yes, please provide provider first and last name: _____

8-Genotype: □ 1a □ 1b □ 2 □ 3 □ 4 □ 5 □ 6
8a-Has documentation been submitted confirming genotype within one year of start date? □ No □ Yes

9-Pre-treatment/baseline HCV RNA: IU/mL: _____ Date taken: _____
10-Hep A&B‡ vaccination series or immunity (please submit documentation/records) □ Completed □ In Progress
(Or if Hepatitis B‡ co-infected, please indicate in diagnosis box #13)
11-Fibrosis (check one) □ F0 □ F1 □ F2 □ F3 □ F4
11a- Cirrhosis (check one): □ No cirrhosis □ Compensated Cirrhosis □ Decompensated Cirrhosis
- **Attach results for fibrosis level via FibroSure / FibroMeter / FibroTest / Imaging / Shear Wave Elastography**

12-Documentation/Score: **Biopsy**_____ **FibroScan** _____ (>7.1 kPa) **FibroMeter/Test/Sure** _____ (>0.48 kPa)
APRI_____ (> 0.7) **FIB-4**_____ (> 1.5) **Shear Wave** _____ (>8.29kPa)
12a-**If FibroTest/FibroMeter/Fibrosure was used, calculation for APRI or FIB-4 for concordance is required**
12b-**If F4, Child-Pugh Score (number): _____**

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13-Please indicate (by checking boxes below) and provide documentation of any applicable diagnoses:

□ Chronic Hepatitis C □ Post-transplant □ Cirrhosis: □ CTP A (5-6) □ CTP B (7-9) □ CTP C (on transplant list)
□ HIV/AIDS □ Hepatitis B‡ □ On transplant list with less than 1 year on the list projected
□ Ascites □ Variceal bleed □ Hepatic encephalopathy □ Leukocytoclastic vasculitis
□ Membranoproliferative glomerulonephritis □ Severe renal impairment (eGFR< 30) □ Fibrosing cholestatic HCV
□ Hepatocellular carcinoma meeting Milan criteria □ Symptomatic cryogobulinemia □ Life expectancy < 1 year

‡ Due to risk of HBV reactivation with DAAs FDA is directing health care professionals to screen and monitor for HBV in all patients receiving DAA treatment.

14-Preferred: Please check the requested preferred treatment regimen in left column below:

	Genotype	Patient Population	Preferred Treatment Regimen	Length of Authorization
☐	1a	No cirrhosis	Viekira* + ribavirin	12 weeks
☐		Treatment naïve and with compensated cirrhosis	Viekira* + ribavirin	12 weeks
☐		Treatment experienced and with compensated cirrhosis	Viekira* + ribavirin	24 weeks
☐	1b	With compensated cirrhosis or no cirrhosis	Viekira*	12 weeks
☐	2	No cirrhosis or with compensated cirrhosis	Epclusa	12 weeks
☐		With decompensated cirrhosis	Epclusa + ribavirin	12 weeks
☐	3	No cirrhosis or with compensated cirrhosis	Epclusa	12 weeks
☐		With decompensated cirrhosis	Epclusa + ribavirin	12 weeks
☐	4	With or without compensated cirrhosis	Technivie* + ribavirin	12 weeks

14a-Non-preferred: If requested regimen is not checked above, then list full Hep C medication regimen (+/- ribavirin) including length of treatment requested AND fill out 14b below:

Drug* (indicate strength if drug is available in more than one strength)	Requested **Length of Treatment**

14b-Please provide documentation below indicating sound rationale for prescribing a non-preferred treatment regimen (this may include, for example, patient specific medical contraindications to a preferred treatment). Note, if request is for a ribavirin ineligible member, documentation and medical notes must be provided for consideration of approval.

_____
_____
_____
_____

***Viekira/Technivie**: Provider attests member will be enrolled in Abbvie proCeed Nurse Connector Program □ No □ Yes
To enroll by Phone: 1-855-984-3547 or Fax: 1-866-299- 1687

All approved treatment regimens will be authorized for an initial approval of 8 weeks. Reauthorizations for refills will not be granted until required documentation is received (week 4 HCV RNA).

- If the week 4 HCV RNA is detectable (>25 copies) while on therapy, HCV RNA will be reassessed in 2 weeks. If the repeated HCV RNA level has not decreased (i.e., >1 log10 IU/ml from nadir) all treatment will be discontinued unless documentation is provided which supports continuation of therapy
- The member MUST receive refills within one week of completing the previous fill. Please allow ample time for reauthorization to occur after HCV RNA levels are submitted.

Please include a cover page and/or indicate number of pages being faxed to ensure complete processing of this request